

FILED APR 5 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **10836**
Registrar's No. **2894**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY 2129	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis Mo.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital		d. STREET ADDRESS (If rural, give location) 2 - 4666a Page Ave.	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
a. (First) Jennie	b. (Middle)	c. (Last) Milton	(Month) March	(Day) 23	(Year) 1950

5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Feb. 22nd, 1914	9. AGE (In years last birthday) 36	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 YEAR Hours	IF UNDER 1 YEAR Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Galesburg, Illinois	12. CITIZEN OF WHAT COUNTRY? U.S.A
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13a. FATHER'S NAME Unknown-- Delpra	13b. MOTHER'S MAIDEN NAME Mary--	14. NAME OF HUSBAND OR WIFE Unknown James Milton
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME James Milton	ADDRESS 4666a Page
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Metastasis Carcinoma of Breast, right, with	Antecedent Causes		Undet.
<i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>	DUE TO (b) _____		
	DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS	Conditions contributing to the death but not related to the disease or condition causing death. None		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 170X
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **3-6**, 1950, to **3-23**, 1950, that I last saw the deceased alive on **3-23**, 1950, and that death occurred at **4:40p** m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Kurt G Phillips, M.D.	23b. ADDRESS 2601 N Whittier St	23c. DATE SIGNED 3-24-50
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 3/28/50	24c. NAME OF CEMETERY OR CREMATORY Saint Peters Cemetery, St. Louis County, Mo.	24d. LOCATION (City, town, or county) (State)
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DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE MAR 27 1950 J. B. Foster	25. FUNERAL DIRECTOR'S SIGNATURE Charles J. Gates, 4107 Finney Ave.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....
Thomas J. Stiles 4059

Signed.....
Student Embalmer

Licensed Embalmer No. ~~4478~~

P. O. Address 4107 Finney Avenue

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

. If this body is not embalmed, fact should be so stated above.